MDS 3.0: The Mini-series
Session #5

Sue Pinette RN

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MDS 3.0 – The Mini-series
Agenda

- Welcome
- Case Mix
- Section M
- Section N
- Section P

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MDS 3.0 History

It all started in 1987 with the OBRA (Omnibus Budget Reconciliation Act) legislation. Government leaders felt that completion of an assessment of the functional abilities/impairments of each resident would help Facility staff to develop a really good Care Plan that was individualized and realistic for each resident.

OBRA's Objective is: "All citizens have the RIGHT to a dignified existence and to have care that permits one to attain or maintain ones highest degree of physical, mental & psycho-social well-being."

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Goals of the MDS 3.0

- **Resident Voice** – MDS 3.0 includes interviews for cognitive function, mood, personal preferences, and pain.
- **Clinical Relevancy** – MDS 3.0 items are based upon clinically useful and validated assessment techniques.
- **Efficiency** – MDS 3.0 sections are formatted to facilitate usability and minimize staff burden.

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CMS Resources for MDS 3.0

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html

RAI Manual: click on RAI manual on left, scroll down to bottom of page.

Item Set (MDS 3.0 Assessment tool): click on RAI technical information on left; scroll down to bottom of page.

Training Portal: www.maine.gov/dhhs/dlrs/mds/training/

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MDS 3.0 – The Mini-series Case Mix

Case Mix Implications for MDS 3.0

Case Mix nurses complete quality assurance reviews to ensure assessments have accurate information. Accurate information ensures accurate payment to the facility and accurate information in our database.

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Case Mix Payment Items

Certain items coded as RUG III services, conditions, diagnoses and treatments on the MDS 3.0 assessment handout.

PDPM refers to payment items for PPS services.

CATS refers to MDS items that "trigger" certain *care area assessment* items used for developing an individualized, resident-specific care plan

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MaineCare Case Mix

Maine uses a modified RUG III Code for Case Mix purposes.

PPS / Medicare uses PDPM HIPPS codes for payment purposes.

Supporting Documentation for Case Mix payment items is required

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Case Mix Weights for RUG III

There are 7 categories:

1. Rehabilitation
2. Extensive
3. Special Care
4. Clinically Complex
5. Impaired Cognition
6. Behavior
7. Reduced Physical Function
8. Default or Not Classified

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Category	ADL Index	End Splits	RUG-III Codes	Maine Weight
Clinically Complex				
Special Care qualifier (see above) and ADL score of 6 or less)	17-18D	***Signs of Depression	CC2	1.826
OR	17-18	No Signs	CC1	1.663
Clinically complex qualifier (any one):	12-16D	Signs of Depression	CB2	1.503
• Burns (M1040F)	12-16	No Signs	CB1	1.389
• Coma (B0100) AND not awake (no crosswalk**) AND ADL dependent (G0110A1, G0110B1, G0110H1, G0110I1)	4-11D	Signs of Depression	CA2	1.331
• Septicemia (I2100)	4-11	No Signs	CA1	1.149
• Pneumonia (I2000)				
• Foot lesion (M1040B, M1040C)/infection (M1040A) AND dressing to foot (M1200I)				
• Internal bleeding (J1550D)				
• Dehydration (J1550C)				
• Feeding tube (K0500B) (calories >= 51%, or calories = 26%-51% (K0700A/K0710A3) AND fluids >= 501 cc (K0700B/K0710B3 = 2))				
• Oxygen therapy (O0100C1, O0100C2)				
• Transfusions (O0100I1, O0100I2)				
• Hemiplegia/hemiparesis (I4900) with ADL score >= 10				
• Chemotherapy (O0100A1, O0100A2)				
• Dialysis (O0100J1, O0100J2)				
• Physician visits (O0600) 1+ days AND order changes (O0700) 4+ days (last 14 days)				
• Physician visits (O0600) 2+ days and order changes (O0700) 2+ days (last 14 days)				
• Diabetes (I2900) with injection (N0300) on 7 days AND order change O0700) 2+ days (last 14 days)				

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MDS 3.0 RUG III ADL Scoring Chart

The ADL index is used to split many of the Clinical Indicator categories. Composed from these ADL activities:

Bed Mobility – Items G011A1 and G0110A2
Transfer – Items G0110B1 and G0110B2
Eating – Items G0110G1, K0500B, K0700A, and K0700B
Toilet Use – Items G0110I1 and G0110I2

The ADL index score is determined as follows:

ADL Function		ADL Score
Bed mobility, Toilet use and Transfer:		
	Self-Performance (column 1) is coded on the MDS 3.0 as:	
	Independence or Supervision (item coded 0,1, or 7)	1
	Limited Assistance (item coded 2)	3
	Extensive Assistance or Total Dependence (item coded 3,4 or 8) **AND** Support Provided (Column 2) is:	
	• None, set-up only or 1 person physical assist (item coded 0, 1, or 2)	4
	• 2+ persons physical assist or activity did not occur (item coded 3 or 8*	5
Eating:		
IF:		
	Resident receives Parenteral/IV (K0500A = 1)	3
	Tube Feeding (K0500B = 1) **AND** one of the following:	
	• 51% or more total calories from parenteral or tube feeding (K0700A = 3)	3
	• 26-50% total calories from parenteral or tube feeding (K0700A = 2) **AND** fluid intake is 501+ ml per day (K0700B = 2)	
IF NOT:		
	Self-Performance (column 1) is:	
	Independent or Supervision (item coded 0, 1, 7)	1
	Limited Assistance (item coded 2)	2
	Extensive Assistance or Total Dependence or Activity Did Not Occur (item coded 3, 4, or 8)	3

The scores for each ADL variable are added to compute the ADL index score. The ADL Index score will range from 4 to 18 for each resident.

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Case Mix Quality Assurance Review

About every six months, a Case Mix nurse reviews a sample of MDS 3.0 assessments and resident records to check the accuracy of the MDS 3.0 assessments.

Insufficient, inaccurate, or lack of documentation to support information coded on the MDS 3.0 may lead to an error.

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Poor documentation could also mean…

Lower payment than the facility could be receiving

OR

Overpayment, which could lead to re-payment to the State (sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.

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Sanctions:

2%	Error rate 34% or greater and less than 37%
5%	Error rate 37% or greater and less than 41%
7%	Error rate 41% or greater and less than 45%
10%	Error rate 45% or greater
10%	If requested reassessments not completed within 7 days

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Documentation errors vs. Payment errors

- A Payment error changes the payment group for the assessment and counts towards the final "error rate" presented at the time of the exit interview.
- A Documentation or clinical error does not change the payment group or count towards the final error rate.
- Both types of errors must be corrected
- Claims adjustments must occur for payment errors.

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Assessment Review Process

- Facilities selected for assessment reviews must provide reviewers with reasonable access to residents, professional and non-licensed direct care staff, the facility assessors, clinical records, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments. (MBM, Ch III, Section 67)
- At the conclusion of the on-site portion of the review process, the Department's reviewers shall hold an exit conference with facility representatives. Reviewers will share written findings for reviewed records.
- At all reasonable times during the prescribed retention period, persons duly authorized by the Department or the federal government, whether employees or contractors, shall be given the right to full access to inspect, review, or audit all medical, quality assurance documents, financial, administrative records, and other documents and reports required to be kept under federal and state laws and regulations. (MBM, Ch 1.03)

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MaineCare Case Mix - Documentation

- Resident interviews will be accepted as coded on the MDS 3.0—NO additional supporting documentation is required.
- Staff interviews **must be documented** in the resident's record. If interviews are summarized in a narrative note, the interviewer must document the **date** of the interview, **name of staff** interviewed, and staff **responses** to scripted questions asked.
- Follow all "Steps for Assessment" in the RAI Manual, for the interview items.

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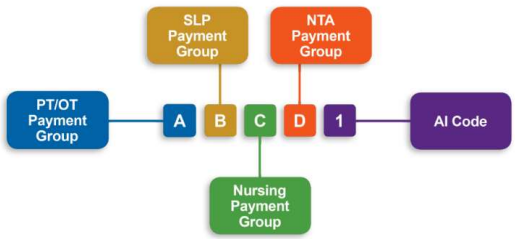
MDS 3.0 – SNF/NF
Chapter 5

• The HIPPS code to be used for Medicare Part A SNF claims is included on the MDS. There are two different items needed:
  − The Medicare Part A HIPPS code (Item Z0100A).
  − PDPM Version Code (Item Z0100B).
• Both of these codes must be submitted to QIES ASAP for PPS assessments (A0310B = 01 or 08).
• Both values are validated by QIES ASAP, and your final validation report will indicate if there are any errors and provide the correct value for any incorrect item.



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MDS 3.0 – PDPM
Payment Implications

Every Medicare Part A Admission is classified into **each** component

PDPM Components - Summary

PT	OT	SLP	NSG	NTA
• Total of 16 different clinical categories • Each has associated CMI • Categories based on primary reason for admission, functional score, and surgery • Rate adjustment applies	• Total of 16 different clinical categories • Each has associated CMI • Categories based on Primary reason for admission, functional score, and surgery • Rate adjustment applies	• Total of 12 different categories • Each has associated CMI • Categories based on neurological condition, comorbidities and cognitive impairment, mechanically altered diet and swallow disorder	• Total of 25 different clinical categories • Similar to RUG-IV nursing categories • Consolidated levels • Includes resident diagnoses, treatments, other characteristics	• Point system • 6 NTA point ranges • Each range has assoc. CMI value • NTA based on over 50 different MDS items and 1 claim item

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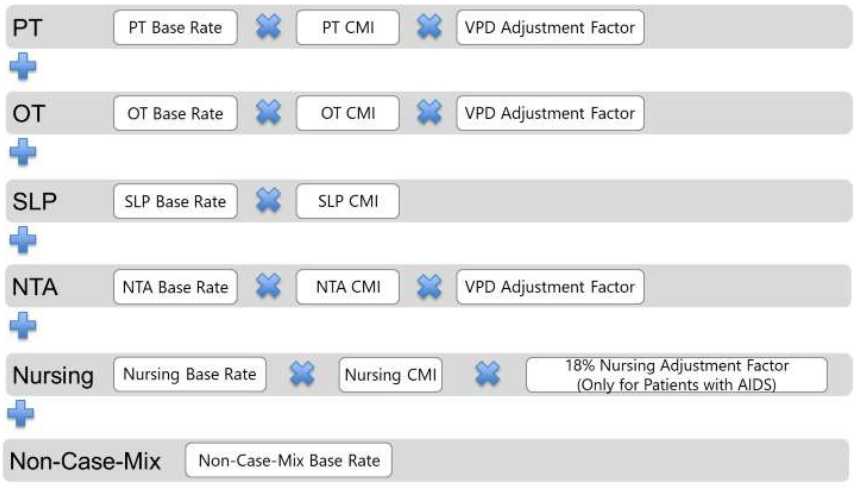
MDS 3.0 – PDPM
Payment Implications



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Visit the portal at:
https://www.maine.gov/dhhs/dlc/licensing-certification/medical-facilities/minimum-data-set-training

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Section M

Section M: Skin Conditions

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

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Section M

http://surveyortraining.cms.hhs.gov/Courses/126/SectionMVideo/SectionMVideo.mp4

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Section M

DEFINITION:
PRESSURE ULCER/INJURY
A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

Section M

M0100: Determination of Pressure Ulcer/Injury Risk
M0150: Risk of Pressure Ulcers/Injuries
M0210: Unhealed Pressure Ulcers/Injuries

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Section M

Section M
M0300 Unhealed Pressure Ulcers

M0300A: Number of Stage 1
M0300B: Number of Stage 2
number present on admission
M0300C: Number of Stage 3
number present on admission
M0300D: Number of Stage 4
number present on admission

DEFINITIONS:
EPITHELIAL TISSUE
New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

GRANULATION TISSUE
Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.

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Section M

CMS has further *adapted* the Section M guidelines to be more consistent with the National Pressure Ulcer Advisory Panel (NPUAP). Thus, all references to **PRESSURE ULCER** throughout Section M have been changed to **PRESSURE ULCER/INJURY.**

Additional external factors, such as excess moisture, microclimate, and tissue exposure to urine or feces, can increase risk. Microclimate = air temperature, humidity, air flow at support surface.

Stage 1 and deep tissue injuries are called "pressure injuries" because wounds are closed

- Stage 2, 3, or 4 or unstageable due to slough or eschar are termed "pressure ulcers" since are usually open wounds
- Unstageable due to non-removable dressing or device use "pressure ulcer/injury" since could be open or closed

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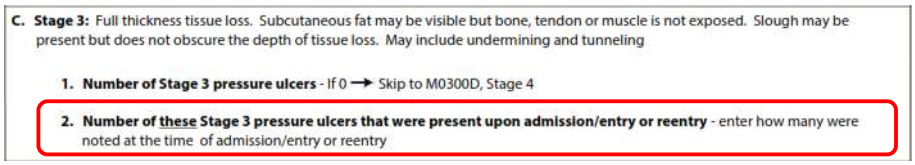
Section M

M0300B2, C2, and D2: Determine "Present on Admission"



C. **Stage 3:** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

2. **Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry** - enter how many were noted at the time of admission/entry or reentry

Was the pressure ulcer/injury present at the time of admission/entry or reentry and **not** acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement.

RAI Manual, Chapter 3, page M-8 and M-9: step 3 through 10 discuss specific examples of admissions and readmissions with pressure ulcer/injuries.

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Section M

M1030: Definitions, RAI Manual, page M-26

VENOUS ULCERS: Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

ARTERIAL ULCERS: Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.

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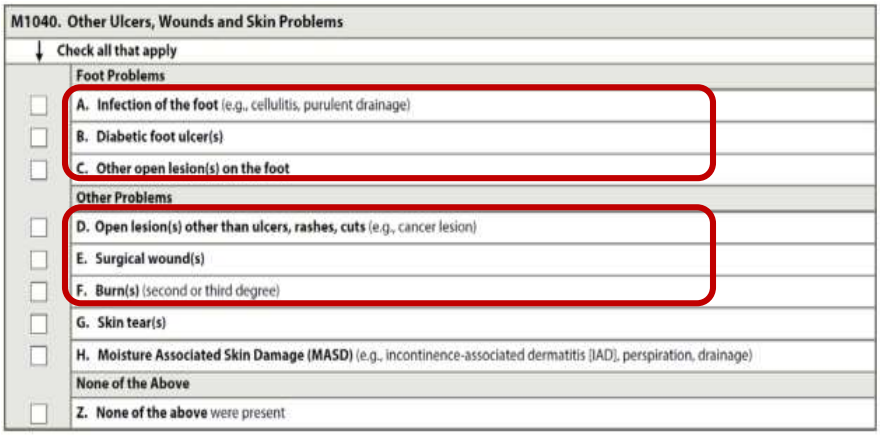
Section M

Section M: **M1040 Other Ulcers, Wounds, and Skin Problems**



M1040. Other Ulcers, Wounds and Skin Problems	
Check all that apply	
	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
☐	**G. Skin tear(s)**
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
	None of the Above
☐	**Z. None of the above** were present

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Section M

Payment items for Section M:

Ulcers (2 sites, any stage (M0300A, M0300B1-D1, M1030)*; or 1 site stage 3 or 4 (M0300C1-D1, F1)*) AND 2+ skin treatments (M1200A-E, G-H)

Surgical wounds (M1040E) AND surgical wound care (M1200F) or application of dressing (M1200G) or application of ointment (M1200H)

Foot lesion (M1040B, M1040C)/infection (M1040A) AND dressing to foot (M1200I)

Open lesions (M1040D) AND surgical wound care (M1200F) or application of dressing (M1200G) or application of ointment (M1200H)

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Section M

Section M: **M1200 Skin and Ulcer/Injury Treatments**

Check all that apply in the last 7 days. Check Z, None of the above were provided, if none applied in the past 7 days.

- **M1200A,** Pressure reducing device for chair
- **M1200B,** Pressure reducing device for bed
- **M1200C,** Turning/repositioning program
- **M1200D,** Nutrition or hydration intervention to manage skin problems
- **M1200E,** Pressure ulcer/injury care
- **M1200F,** Surgical wound care
- **M1200G,** Application of non-surgical dressings (with or without topical medications) other than to feet. Non- surgical dressings do not include Band-Aids.
- **M1200H,** Application of ointments/medications other than to feet
- **M1200I,** Application of dressings to feet (with or without topical medications)
- **M1200Z,** None of the above were provided

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Section M

M1200 Skin and Ulcer/Injury Treatments

A. Pressure reducing device for chair

B. Pressure reducing device for bed

- do **not** include egg crate cushions of any type, donut or ring devices for chairs

C. Turning/repositioning program

- *Specific* approaches for changing resident's position and re-aligning the body
- *Specific* intervention and frequency
- Requires supporting documentation of monitoring and periodic evaluation

D. Nutrition and hydration

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Section M

M1200 Skin and Ulcer/Injury Treatments (continued)

E. Pressure Ulcer Care
F. Surgical Wound Care
G. Non-surgical Dressing (other than feet): Do NOT include Band-Aids or steri-strips
H. Ointments/medications (other than feet)
I. Dressings to feet
Z. None of the above

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Section N

Section N: Medications

Intent: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin, and/or select medications were received by the resident.

In addition, an Antipsychotic Medication Review has been included. Including this information will assist facilities to evaluate the use and management of these medications.

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Section N

Section N: INJECTIONS

N0300

Record the number of days (during the 7-day look-back period) that the resident received **any** type of medication, antigen, vaccine, etc.

Insulin injections are coded in Item N0300 as well as in Item N0350.

Note: N0300 is a RUG III payment item and N0350 is a PDPM payment item for insulin injections.

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Section N

Section N: INJECTIONS

N0350 Insulin: *Not a payment item for **RUG III** (MaineCare), but is a payment item for **PDPM** (Medicare) and will counts toward the PDPM HIPPS code for standalone OBRA assessments.*

A. Insulin Injections administered
B. Orders for insulin – the number of days the physician changed the insulin orders in the seven (7) day look back.

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Section N

Section N Medications

N0410 Medications Received

1. Antipsychotic
2. Antianxiety
3. Antidepressant
4. Hypnotic
5. Anticoagulant
6. Antibiotic
7. Diuretic
8. Opioid (9 implications to CAAs)

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Section N

Section N New Drug References

The following resources and tools provide information on medications including classifications, warnings, appropriate dosing, drug interactions, and medication safety information.

- GlobalRPh Drug Reference: http://globalrph.com/drug-A.htm
- USP Pharmacological Classification of Drugs: http://www.usp.org/usp-healthcare-professionals/uspmedicare-model-guidelines/medicare-model-guidelinesv50-v40#Guidelines6 *Directions:* Scroll to the bottom of this webpage and click on the pdf download for "USP Medicare Model Guidelines (With Example Part D Drugs)"
- Medline Plus: https://www.nlm.nih.gov/medlineplus/druginformation.html

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Section N

Section N0450 Antipsychotic Medication Review

N0450. Antipsychotic Medication Review

Enter Code ☐

A. Did the resident receive antipsychotic medications since admission/entry or reentry or the prior OBRA assessment, whichever is more recent?

0. **No** - Antipsychotics were not received → Skip N0450B, N0450C, N0450D, and N0450E
1. **Yes** - Antipsychotics were received on a routine basis only → Continue to N0450B, Has a GDR been attempted?
2. **Yes** - Antipsychotics were received on a PRN basis only → Continue to N0450B, Has a GDR been attempted?
3. **Yes** - Antipsychotics were received on a routine and PRN basis → Continue to N0450B, Has a GDR been attempted?

Enter Code ☐

B. Has a gradual dose reduction (GDR) been attempted?

0. **No** → Skip to N0450D, Physician documented GDR as clinically contraindicated
1. **Yes** → Continue to N0450C, Date of last attempted GDR

C. Date of last attempted GDR:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

D. Physician documented GDR as clinically contraindicated

0. **No** - GDR has not been documented by a physician as clinically contraindicated → Skip N0450E Date physician documented GDR as clinically contraindicated
1. **Yes** - GDR has been documented by a physician as clinically contraindicated → Continue to N0450E, Date physician documented GDR as clinically contraindicated

E. Date physician documented GDR as clinically contraindicated:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

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Section N

RAI Manual, page N14

- If the resident was admitted to the facility with a documented GDR attempt in progress and the resident received the last dose(s) of the antipsychotic medication of the GDR in the facility, then the GDR would be coded in N0450B and N0450C.
- Discontinuation of an antipsychotic medication, even without a GDR process, should be coded in N0450B and N0450C as a GDR, as the medication was discontinued. When an antipsychotic medication is discontinued without a gradual dose reduction, the date of the GDR in N0450C is the first day the resident did not receive the discontinued antipsychotic medication.
- The start date of the last attempted GDR should be entered in N0450C, Date of last attempted GDR. The GDR start date is the first day the resident received the reduced dose of the antipsychotic medication.

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Section N

Section N

Three (3) new items: **Drug Regimen Review**

item	Assessed on:
N2001. Drug Regimen Review (DRR)	Admission (5-day)
N2003. Medication Follow - up	Admission (5-day)
N2005. Medication Intervention	PPS Discharge

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Section N

N2001 Drug Regimen Review

Intent: The intent of the drug regimen review items is to document whether a drug regimen review was conducted upon the resident's admission (start of Skilled Nursing Facility [SNF] Prospective Payment System [PPS] stay) and throughout the resident's stay (through Part A PPS discharge) and whether any clinically significant medication issues identified were addressed in a timely manner.

N2001. Drug Regimen Review - Complete only if A0310B = 01

Enter Code ☐

Did a complete drug regimen review identify potential clinically significant medication issues?

0. **No** - No issues found during review
1. **Yes** - Issues found during review
9. **NA** - Resident is not taking any medications

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Section N

N2001: Drug Regimen Review (cont.)

Steps for Assessment

Complete if A0310B = 01.

1. Complete a drug regimen review upon admission (start of SNF PPS stay) or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues.

2. Review medical record documentation to determine whether a drug regimen review was conducted upon admission (start of SNF PPS stay), or as close to the actual time of admission as possible, to identify any potential or actual clinically significant medication issues.

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Section N

Potential or Actual Clinically Significant Medication Issue

A clinically significant medication issue is a *potential or actual* issue that, in the clinician's professional judgment, warrants physician (or physician-designee) communication and completion of prescribed/recommended actions by midnight of the next calendar day at the latest.

"Clinically significant" means effects, results, or consequences that materially affect or are likely to affect an individual's mental, physical, or psychosocial well-being, either positively, by preventing a condition or reducing a risk, or negatively, by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication issue for the purpose of the drug regimen review items.

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3. Clinically significant medication issues may include, but are not limited to:

- Medication prescribed despite documented medication allergy or prior adverse reaction.
- Excessive or inadequate dose.
- Adverse reactions to medication.
- Ineffective drug therapy.
- Drug interactions (serious drug-drug, drug-food, and drug-disease interactions).
- Duplicate therapy (for example, generic-name and brand-name equivalent drugs are co-prescribed).
- Wrong resident, drug, dose, route, and time errors.

continued on next slide…

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3. Clinically significant medication issues may include, but are not limited to: (cont.)

- Medication dose, frequency, route, or duration not consistent with resident's condition, manufacturer's instructions, or applicable standards of practice.
- Use of a medication without evidence of adequate indication for use.
- Presence of a medical condition that may warrant medication therapy (e.g., a resident with primary hypertension does not have an antihypertensive medication prescribed).
- Omissions (medications missing from a prescribed regimen).
- Nonadherence (purposeful or accidental).

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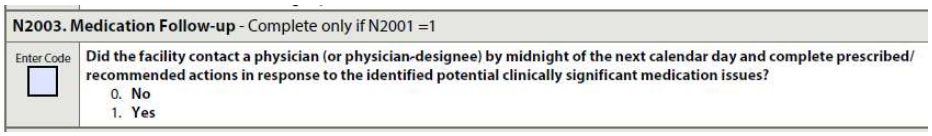
Section N



N2003. Medication Follow-up - Complete only if N2001 =1

Enter Code

Did the facility contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/ recommended actions in response to the identified potential clinically significant medication issues?

0. No
1. Yes

Definition: Medication Follow-Up

The process of contacting a physician to communicate an identified medication issue and completing all physician-prescribed/recommended actions by midnight of the next calendar day at the latest.

This item is completed if one or more potential or actual clinically significant medication issues were identified during the admission drug regimen review (N2001 = 1).

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Section N

Steps for Assessment

1. Review the resident's medical record to determine whether the following criteria were met for any potential or actual clinically significant medication issues that were identified upon admission:

   - Two-way communication between the clinician(s) and the physician was completed by midnight of the next calendar day, AND
   - All physician-prescribed/-recommended actions were completed by midnight of the next calendar day.

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Section N

Definition: Contact with Physician

- Communication with the physician to convey an identified potential or actual clinically significant medication issue, *and a response* from the physician to convey prescribed/recommended actions in response to the medication issue.
- Communication can be in person, by telephone, voice mail, electronic means, facsimile, or any other means that appropriately conveys the resident's status.

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Section N

N2005. Medication Intervention - Complete only if A0310H = 1

Enter Code ☐

Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?

0. **No**
1. **Yes**
9. **NA** - There were no potential clinically significant medication issues identified since admission or resident is not taking any medications

Every time a potential or actual clinically significant medication issue is identified throughout the resident's stay, it must be communicated to a physician, and the physician-prescribed/-recommended actions must be completed by the clinician in a time frame that maximizes the reduction in risk for medication errors and resident harm.

The observation period for this item is from the date of admission (start of SNF PPS stay) through discharge (Part A PPS discharge).

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MDS 3.0 – The Mini-series
Section P

Section P: Restraints and Alarms

Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definition in the appropriate categories.

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Section P

Section P: Restraints

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. Not used
1. Used less than daily
2. Used daily

↓ Enter Codes in Boxes

	Used in Bed
☐	A. Bed rail
☐	B. Trunk restraint
☐	C. Limb restraint
☐	D. Other
	Used in Chair or Out of Bed
☐	E. Trunk restraint
☐	F. Limb restraint
☐	G. Chair prevents rising
☐	H. Other

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Section P

Section P: Restraints

P0200. Alarms	
An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected	
	↓ Enter Codes in Boxes
Coding: 0. Not used 1. Used less than daily 2. Used daily	☐ A. Bed alarm ☐ B. Chair alarm ☐ C. Floor mat alarm ☐ D. Motion sensor alarm ☐ E. Wander/elopement alarm ☐ F. Other alarm

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Section P

Section P: Restraints

Coding Tips for Alarms and Restraints:

- When coding this section, do not consider as a restraint a locked/secured unit or building in which the resident has the freedom to move about the locked/secured unit or building. Additional guidance regarding locked/secured units is provided in the section "Considerations Involving Secured/Locked Areas" of F603 in Appendix PP of the State Operations Manual.
- When an alarm is used as an intervention in the resident's safety strategy, the effect the alarm has on the resident must be evaluated individually for that resident.
- When determining whether the use of an alarm also meets the criteria of a restraint, refer to the section "Determination of the Use of Position Change Alarms as Restraints" of F604 in Appendix PP of the State Operations Manual.

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MDS 3.0 – The Mini-series Session #5

Questions?

Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00

Call the MDS Help Desk to register!

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MDS 3.0 – The Mini-series Session #5

Reminders!

- This completes *Session 1* of the MDS 3.0 training. Thank you for attending.
- Ask questions!
- Ask more question!!
- Use your resources (other MDS coordinators, case mix staff, MDS Help Desk, Forum Calls etc.)
- Attend training as often as you need.

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MDS 3.0 – The Mini-series Session #1

Contact Information:

- **MDS Help Desk**: 624-4095 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- **Lois Bourque, RN**: 592-5909
  Lois.Bourque@maine.gov
- **Deb Poland, RN, RAC-CT**: 215-9675
  Debra.Poland@maine.gov
- **Christina Stadig RN, RAC-CT:** 446-3748
  Christina.Stadig@maine.gov
- **Emma Boucher RN, RAC-CT**: 446-2701
  Emma.Boucher@maine.gov
- **Sue Pinette, RN, RAC-CT**: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

Training Portal: www.maine.gov/dhhs/dlrs/mds/training/

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Questions?

Sue Pinette RN, RAC-CT
Case Mix Manager, State RAI Coordinator
(207) 287-3933

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